DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH 6

Primary Registration District No. 1002

State File No. 9645

Registrar's No. 1079

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2122 Mercier St. K. C. Mo. (If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community about 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 0

(d) Street No. 2122 Mercier St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? about 10 yrs. years.

3. (a) PRINT FULL NAME Carman Martinez 635

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race Mex.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jose Martinez

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased May (Month) 15 (Day) 1863 1864 (Year)

8. AGE: Years 76 | Months 9 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Mexico (City, town, or county) (State or foreign country)

10. Usual occupation Housewife 3

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Mexico (City, town, or county) 3 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Mexico (City, town, or county) 3 (State or foreign country)

16. (a) Informant's own signature Jose Martinez

(b) Address 2122 Mercier St. K. C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 9 40 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address 2332 Monitor Place

19. (a) Mch 8, 1940 (Date received local registrar) (b) M. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8 16 year 1940 hour 8:30 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1-14, 19 40, to 3-8, 19 40; that I last saw h[illegible] alive on 3-8, 19 40; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Senility	
Due to	
Due to old age.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed..... Blaine E. Weikert

Licensed Embalmer No..... 4075

P. O. Address 2332 Montana Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9645 —
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No..... Registered No. 1079

(c) City..... (d) Street No. 2122 Mercier St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., If of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Carmen Martinez

(a) Residence, No..... St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Mex	

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	76	9	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

17. INFORMANT.....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE.....19....

19. FUNERAL DIRECTOR.....
(ADDRESS)

20. FILED Mar 8, 1940 M. M. Browne
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 8, 1940

22. I HEREBY CERTIFY, That I attended deceased from .....19....to.....19....

I last saw h..... alive on.....19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance: Mitral insufficiency

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury.....19....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Henry J. Davis, M. D.

(Address) Kansas City, Mo.

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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-1-40
1 X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9645

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1079

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town ..... (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Carman Martinez
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex F
5. Color or race Mex
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife .....
6. (c) Age of husband, or wife, if alive .....
7. Birth date of deceased May (Month) 15 (Day) 1864 (Year)

8. AGE: Years 76 Months 9 Days 23 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) 3/18/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 8
year 1940 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature Henry D. Gillis (M. D. or other)
Address Martinsburg Mo Date signed .....